Summary of Coverage

Employer: Board of Franklin County Commissioners

ASA: 659146

SOC: 1A

Issue Date: March 26, 2006

Effective Date: April 1, 2006

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING A FRAUD AGAINST THE PROVIDER OF BENEFITS, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF A CRIME OF FRAUD AGAINST THE LEGAL ENTITY PROVIDING BENEFITS UNDER THIS PLAN.

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

This Summary of Coverage may be an electronic version of the Summary of Coverage on file with your Employer and Aetna Life Insurance Company. In case of any discrepancy between an electronic version and the printed copy which is part of the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth in such group insurance contract will prevail. To obtain a printed copy of this Summary of Coverage, please contact your Employer.

Eligibility

Employees

You are in an Eligible Class if you are:

- a regular full-time employee, an employee represented for collective bargaining purposes by any labor union, a disabled employee or an elected official in Fairfield, Franklin or Pickaway Counties; or
- a regular full-time employee of Capital City Lodge and you are represented for collective bargaining purposes by any labor union,

and you are in an area which there are Preferred Care Providers. Your Employer will provide you with this information. Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the first day of the calendar month coinciding with or next following the date you complete a probationary period of 30 days of continuous service for your Employer or, if later, the date you enter the Eligible Class.

PPO Dental (Plans A & H)

Dependents

You may cover your:

- wife or husband; and
- unmarried children who are under 19 years of age. Coverage will cease on the day the dependent turns 19.

Any other unmarried child under age 23 who goes to school on a regular basis and depends solely on you for support will be covered as a dependent. Coverage will cease on the last day of the calendar month the unmarried child turns 23 or on the last day of the calendar month in which they graduate, whichever comes first.

Minimum credit hours the unmarried child needs to qualify as a full time student:

- 10 credit hours per quarter or semester for undergraduates; or
- 6 credit hours per quarter or semester for graduate students.

Please note: Students can take one quarter or semester off per year.

Your children include:

- Your biological children.
- Your adopted children.
- Your stepchildren.
- Your dependent children of a qualified dependent child.

No person may be covered as a dependent of more than one employee. This does not apply to a child whose parents are each covered under this Plan both as an employee and as a dependent.

To figure benefits for a person who is covered as an employee and a dependent, or as a dependent of more than one employee, the terms of this Plan will apply separately.

Enrollment Procedure

You will be required to enroll in a manner determined by Aetna and your Employer. This will allow your Employer to deduct your contributions from your pay. Be sure to enroll within 31 days of your Eligibility Date.

Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details.

Effective Date of Coverage

Employees

Your coverage will take effect on the later to occur of:

- your Eligibility Date; and
- the date you return your signed form.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions.

Health Expense Coverage

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

Comprehensive Dental Expense Coverage

Deductible Amounts

Calendar Year Deductible The Calendar Year deductible applies to all Non-Preferred Care expenses	$ 25

The Benefits Payable

After any applicable deductible, the Dental Expense Benefits payable under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Dental Expense which is incurred, except for any different benefit level which may be provided later in this Booklet. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide dental services or supplies at a Negotiated Charge. See your Employer for a copy of the Directory which lists these health care providers.

Any charge for a service or supply furnished by a Preferred Care Provider in excess of such provider's Negotiated Charge for that service or supply will not be a covered expense under the group contract. This rule will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are payable.

If any expense is covered under one type of Covered Dental Expense, it cannot be covered under any other type.

Payment Percentage

The Payment Percentage applies after any deductible amounts.

	Preferred Care	Non-Preferred Care
Type A Expenses	100%	90%
Type B Expenses	80%	70%
Type C Expenses	80%	60%
Orthodontic Treatment	75%	75%

Benefit Maximums
(Read the coverage section in your Booklet for a complete description of the benefits available.)

Calendar Year Maximum $ 1,100

All Preferred and Non-Preferred Covered Dental Expenses apply to this Calendar Year Maximum. However, when $ 1,000 of such Covered Dental Expenses have been applied to this maximum, no benefits will be paid for any further Non-Preferred expenses incurred under this Plan.

Orthodontic Lifetime Maximum $ 1,100

All Preferred and Non-Preferred expenses for orthodontia apply to this Orthodontic Lifetime Maximum. However, when $ 1,000 of such Covered Dental Expenses have been applied to this maximum, no benefits will be paid for any further Non-Preferred expenses incurred under this Plan.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the group contract, except that an increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of dental benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

KEEP THIS SUMMARY OF COVERAGE
WITH YOUR BOOKLET